Supreme Court, U. S.
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No. 80-635

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1980

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., AND LAWRENCE FERGUSON, M.D.

Petitioners,

v.

ARTHUR F. QUERN, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTION PRESENTED

Whether a participating state in administering its Medicaid program is required to recognize and compensate as a provider of qualified services a medical corporation consisting of physicians who provide quality treatment to indigent patients.

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ARTHUR F. QUERN, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Petitioners, Michael Reese Physicians and Surgeons, S.C., ("Michael Reese Corporation") and Lawrence Ferguson, M.D., respectfully request that a writ of certiorari issue to review the judgment entered July 18, 1980 of the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The preliminary injunction order of the District Court for the Northern District of Illinois is unreported, and appears in the Appendix hereto. (App. 1a.) The opinion of the Court of Appeals for the Seventh Circuit is reported at 606 F.2d 732 and appears in the Appendix hereto. (App. 7a.) The opinion of the Court of Appeals for the Seventh Circuit upon rehearing *in banc* is not yet reported, and appears in the Appendix hereto. (App. 17a.)

JURISDICTION

The judgment of the Court of Appeals for the Seventh Circuit, upon rehearing *in banc,* was entered on July 18, 1980, and this petition was filed within 90 days thereafter. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

United States Code, Title 42 § 1396a(a)(23). A State plan for medical assistance must—

* * *

> (23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services. . . .

* * *

United States Code Title 42, § 1396a(a)(32). A State plan for medical assistance must—

* * *

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

* * *

STATEMENT OF THE CASE

The facts found by the District Court and by the Court of Appeals, which are largely undisputed, follow.

To effectively treat at the Michael Reese Medical Center, a large urban hospital complex, the large number of indigent patients who arrive in need of a broad spectrum of experienced and specialized physician services, petitioner[1] Michael Reese Corporation was organized in December of 1972. The petition-

[1] The other petitioner, Lawrence Ferguson, as a doctor employed by Michael Reese Corporation, has also been adversely affected by the decisions of the Court of Appeals. Since Michael Reese Corporation, however, is the principal focus of the facts and of the issues involved, "petitioner" hereafter refers to the corporation.

er employs over three hundred physicians engaged in virtually every specialty, and most of whom also maintain a private practice. As an institutional organization devoted exclusively to providing physician services, the petitioner furnishes its doctors with a variety of expensive, sophisticated medical equipment and resources which would otherwise be unavailable to them individually. The petitioner accounts for and retains the fees generated by its physicians providing services as an employee.

Since its inception, the petitioner has provided quality physician services for thousands of Medicaid patients at Michael Reese Medical Center. Prior to the corporation's formation, the indigent patients at the Medical Center were limited to treatment primarily from interns and residents, rather than from the experienced specialists employed by petitioner.

The Illinois Department of Public Aid ("IDPA") administers the Illinois Medicaid program pursuant to Title XIX to the Social Security Act, 46 U.S.C. § 1396, *et seq.* (the "Medicaid Act"). From the petitioner's inception until October, 1977, the Medicaid payment vouchers for the services of its physicians were mailed by IDPA directly to the security lock box designated by petitioner. These payment vouchers were improperly made payable to the petitioner's employees rather than to the corporation which IDPA refused to recognize as a provider of medical services. In May 1974, IDPA represented to petitioner that it would reverse this position and commence paying the corporation as a provider of physician services, rather than petitioner's employees.

The promised change never occurred. Instead, in October 1977, IDPA initiated a decision to mail payment vouchers to only one address designated by each individual physician, and refused again to recognize corporate providers of physician services. The payment vouchers earned by the corporation were thus made payable to each of the petitioner's hundreds of employee-physicians, and mailed to the employees' private practices. As a result, the ability of petitioner to monitor and

properly account for payment to its physicians for Medicaid services was so diminished that without judicial relief it spelled the end of the corporation to the detriment of its patients.

Shortly after the IDPA directive was issued, this action was filed challenging both IDPA's rejection of medical corporations as providers under the Medicaid Act, and its one address mailing policy. On June 30, 1978, the District Court entered a preliminary injunction order which enjoined IDPA from sending Medicaid payment vouchers relating to physician services performed by petitioner to any address other than the mailing address designated by petitioner.

On September 24, 1979, the Seventh Circuit Court of Appeals reversed the decision of the District Court, and on July 18, 1980 the Seventh Circuit Court of Appeals, after rehearing *in banc,* affirmed the reversal. The decision *in banc* held that the Medicaid Act does not prohibit states from refusing either to pay or to send payments to medical corporations for their physician services. The two dissenting judges squarely disagreed with this interpretation of the Medicaid Act.

Because of the important issues of federal law broadly affecting publicly supported health aid to the indigent, a writ of certiorari is sought by petitioner.

REASONS FOR GRANTING THE WRIT

The Question Of Whether The Medicaid Act Permits State Medicaid Plans To Arbitrarily Exclude Medical Corporations As Recognized Medicaid Providers Presents Significant Issues Of Federal Law Which Should Be Resolved By This Court.

This case squarely addresses the question of whether the Medicaid Act allows a participating state to inexplicably refuse to recognize medical corporations as legitimate institutional providers of medical care to the needy. Specifically, this petition principally raises the pervasive question of whether

federal law requires that state Medicaid plans recognize medical corporations as providers of medical services to whom payment shall be made. It further implicates the issue of whether federal law guarantees to Medicaid recipients the right to choose qualified medical corporations as their provider of physician services. These dual questions of federal law have a major impact on the administration of the federal Medicaid program, and an even greater affect on the degree to which this nation's needy are provided adequate medical care.

I.

Exclusion Of Medical Corporations From The Medicaid Program Relegates The Needy To Inferior Medical Care.

In 1965 Congress adopted the Medicaid Act as Title XIX to the Social Security Act. The avowed purpose of the Medicaid program was to bring the poor into the mainstream of American medical services. Hearings before the Subcommittee on Medicaid of the Senate Finance Committee, 91st Cong., 2d Sess., pt. 1 at 57 (1965); *See also Bay Ridge Diagnostic Laboratory, Inc.* v. *Dumpson,* 400 F.Supp. 1104, 1105, (E.D.N.Y. 1975). Consonant with this objective, the Act expressly mandates that states participating in this federal program administer their state plans in the "best interests of the recipients." 42 U.S.C. § 1396a(a)(19). By systematically excluding medical corporations from participating in its state Medicaid program, Illinois is unjustifiably disregarding the real and positive contribution of such corporations to achieving the public health objectives of the Medicaid Act[2] as is illustrated by this case.

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[2] Although IDPA refuses to recognize medical corporations as Medicaid providers, the Illinois legislature has endorsed the propriety of medical corporations by licensing them "to own, operate, and maintain an establishment for the study, diagnosis, and treatment of human ailments and injuries. . ." Ill. Rev. Stat., ch. 32, § 632.

Group medical practice in this country has grown steadily since it was first advocated in 1927 as a method for more effective delivery of health services. Group Medical Practice in the United States 1975, Center for Health Services Research and Development, p. 4. A 1975 survey of the contribution of group medical practices identified 8,483 group medical practices in the United States encompassing 66,842 physicians. *Id.* at 4.[3] Nearly 59% of these group practices are engaged in multispecialty organizations while 61% are professional corporations. *Id.* at 4-7. This survey confirms the obvious—the medical corporation is a widely accepted mode of delivery of physician services to the public.

Petitioner Michael Reese Corporation demonstrates the unique benefits which medical corporations are better able to offer the Medicaid patient. Michael Reese Corporation's hundreds of employee-physicians provide expertise in a great diversity of specialties. Unlike the sole practitioner, a group practice affords markedly expanded opportunities for consultation and interchange between and within the increasingly specialized fields of medicine. Only a group practice such as petitioner could have experienced physicians at the hospital through day and night, a service indispensable for such treatment as the voluminous intensive care and emergency care typical of an urban medical facility. In this instance, the petitioner has been able to purchase the latest, sophisticated health care equipment and devices for treatment of patients which the individual physician could not afford. In the matter of publicly supported health services, there are also the commendable efficiencies in sharing office space, recordkeeping, and billing. Perhaps most significant, the group practice of a

[3] The study defined group medical practice as the application of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis, or treatment through joint use of equipment and personnel, and with the income from the medical practice distributed in accordance with methods previously determined by members of the group.

medical corporation furnishes an institutional framework for attracting experienced physicians to treat the needy. The petitioner has thus provided thousands of indigent patients with necessary treatment which highly specialized, experienced physicians have performed more effectively than could interns and residents.

The consequence of the erroneous interpretation given the Medicaid Act by the IDPA, as affirmed by the Court of Appeals, is, as recognized by the dissent, ". . . that the corporate plaintiff will be forced to close shop." (App. 22a.) Such a needlessly harsh result of banishing medical corporations from the Medicaid program, as represented by this case, undeniably leaves to the more needy the lesser treatment. Hence, the issue of whether the Medicaid Act allows a state to arbitrarily exclude all medical corporations from the Medicaid program presents a federal question of the significant importance which this Court historically has accepted.[4]

II.

The Medicaid Act Mandates That State Medicaid Plans Include Medical Corporations As Providers To Whom Payment Shall Be Made.

A state is not obliged to conduct a federal Medicaid program, but if it elects to do so, it must comply with the requirements of the Medicaid Act. 42 U.S.C. §§ 1396a, 1396c; *See e.g., Harris* v. *McRae,* U.S. 100 S.Ct. 2671 (1980). Section

[4] The Illinois State Medical Society, a statewide organization representing in excess of 14,000 physicians, or more than 80% of the licensed physicians in Illinois, has formally denounced IDPA's exclusion of medical corporations from its Medicaid program as an unreasonable and arbitrary exclusion of an acceptable arrangement for delivery of medical treatment.

1396a(a)(32) sets forth mandatory payment standards for state Medicaid plans, stating in pertinent part:

> (a) A state plan for medical assistance must—
>
> * * *
>
> (32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise;

42 U.S.C. § 1396a(a)(32).

This provision requires that a state Medicaid plan must pay the "person" providing care or service. The use of the term "person" in federal law explicitly includes corporations as well as individuals, unless the context of usage indicate otherwise. 1 U.S.C. § 1.[5] In this instance, the term "person" deliberately used throughout the Medicaid Act is further expressly defined to include corporations. 42 U.S.C. § 1301(a)(3).

The clear mandate to compensate persons so as to include corporations is particularly confirmed by the fact that prior to the 1977 Medicare-Medicaid Antifraud and Abuse Amendments to the Social Security Act, Section 1396a(a)(32) only provided that no payment "shall be made to anyone other than such individual [receiving treatment], or such physician, dentist, or practitioner . . . ." In view of this statutory amendment, the dissent correctly concluded that "it follows then that Congress explicitly permitted a corporation such as Michael Reese Physicians & Surgeons, S.C. . . . to receive the payments at issue here." (App. 19a)

Other provisions of the Medicaid Act manifest the intention of Congress that group practices, such as medical

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[5] Indeed, absent explanatory context, federal provisions which utilize the term "person" are construed to include corporations. *See, e.g., U.S.* v. *A&P Trucking Co.*, 358 U.S. 121 (1958); *Bay Ridge Diagnostic Laboratory, Inc.* v. *Dumpson*, 400 F.Supp. 1104 (E.D.N.Y. 1975).

corporations, are to be recognized as qualified Medicaid providers. A state must ensure that 90% of certain payment claims for services furnished by "health care practitioners through individual or group practices or through shared health facilities" be paid within 30 days of receipt. 42 U.S.C. § 1396a(a)(37). Providers "other than an individual practitioner or group of practitioners" shall identify persons with a greater than 5% ownership interest. 42 U.S.C. § 1320a-3. Similarly, an entity, other than an individual practitioner or a group of practitioners must supply information concerning ownership interest of entities with which it has significant business relations. 42 U.S.C. § 1396a(a)(38). Furthermore, regulations of the Department of Health and Human Services require that a state plan provide that when the Medicaid "provider is in other than solo practice, identification shall depend upon the group's billing practices; where billing is by the individual, that identification shall be by social security number; where billing is by a partnership or a corporation, then identification shall be by employer identification number." 45 C.F.R. § 250.71(a).

In the face of the foregoing evidence that "person" means a corporation as well as an individual and while acknowledging that the statute is not without ambiguity, the majority of the Court of Appeals nonetheless decided that the state has unreviewable discretion to exclude a corporate group practice. This ruling was essentially premised in two respects. First, the majority held that Congress vested the state with such discretion to curb the abuses from the assignment of medical bills to agents for collection (factors), and from unscrupulous "medicaid mills" which submit fabricated bills at the public expense. But as the dissent cogently responded "the majority opinion unfortunately perpetuates a rigidly anserine bureaucratic ruling to the detriment of an orderly handling of the needs of public health". (App. 14a). The petitioner is a provider of medical services through its employee-physicians entitled to recognition as such, not a bill collector divorced from

the dispensing of medical care.[6] Further, there is no suggestion that petitioner is a "medicaid mill". To the contrary, its dedication to the public interest is exemplified in this record. In any event, the disputed ruling multiplies the concern of accountability from one centralized, responsible recordkeeper to over three hundred individual physicians. Finally, the majority opinion fails to dispel the clear statutory pronouncements[7] that

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[6] In his examination of the legislative history, Judge Cummings in dissent found a compelling record reflecting "Congress' command that state plans must prevent a physician from employing a power of attorney but preserve his ability to use an agent [such as petitioner]." (App. 21a, 22a)

[7] The majority buttresses its conclusion that the statute is discretionary by dismissing the mandatory language of the statute and by emphasizing its exception providing that payment "may" be made to an employer of a physician if the latter is required to turn over his fees to the employer. Again, Judge Pell in dissent articulated the following sound analysis:

> I agree with the majority that on the matter of legislative intent, resort should be first had to the words of the enactment themselves. Here the basic statute, pre-exceptions, requires that the plan "must provide" that no payment shall be made to anyone other than the provider of the service. The exceptions clauses do not state that nevertheless the plan may provide for the payment to be made to the employer of the provider of service; instead the exceptions deal with the actual payment notwithstanding the mandatory language required for the plan. This could not very well have been worded in terms that in the event of employment the payment "shall" be made to the employer. Conceivably some employers might prefer that the physician directly do the billing with the amounts received to be credited against his salary obligation. In other words, the "may" in the statute just as logically, because it deals with the payment not the provisions of the plan, can be construed to refer to a discretion on the part of the employer to determine whether or not its employees directly shall bill for and receive payments.

(App. 15a).

a corporate group practice is a "person" fully entitled to equal treatment[8] as a provider of medical services.

The second element of the majority opinion is that the rejection of medical corporations and the concomitant one address rule is merely an administrative inconvenience to petitioner which is curable by each of its individual physicians designating the corporation as his or her address. This unrealistic approach simply fails to apprehend that most of petitioner's physicians have private practices often including other Medicaid patients, which creates insurmountable problems of accounting for petitioner's Medicaid compensation. Further, the majority decision exalts an exaggerated necessity for bureaucratic power over the real exigencies and statutory rights of the petitioner. In short, this ruling strikes at the fundamental purpose of the Michael Reese Corporation to auger its doom.

In the final analysis, there is more at stake here than the tension between an obdurate bureaucracy and the subject of its regulation which threatens petitioner's very existence. There is also more at issue than the fact that absent relief from this Court, future indigent patients will be deprived of choosing petitioner for medical treatment as federal law ensures.[9] The

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[8] Indeed, the invidious disparity accorded a corporate group practice as compared to other medical institutions, such as clinics or hospitals does implicate "serious constitutional questions" as Judge Pell in dissent noted. In the interest of brevity, those questions, which were argued to the Court of Appeals are not discussed in this petition. Suffice it to say that if this exercise in bureaucracy were literally imposed upon such institutions, Medicaid payments could only be made directly to the individual rendering the service, whether it be an intern or hospital orderly.

[9] In *Bay Ridge Diagnostic Laboratory Inc.* v. *Dumpson,* 400 F. Supp. 1104 (E.D.N.Y., 1975), a state medicaid program at the urging of a corporate medical provider was enjoined from reducing the scope of medical laboratory services, even though it was intended to save costs, because such action denied patients "freedom of choice"

(Footnote continued on following page)

additional and decisive factor that impels a judgment to grant this writ is that in ostracizing petitioner from the Medicaid program despite its unchallenged qualifications and in violation of federal law, the noble ideal of the Medicaid program of conferring upon the poor equal access to this nation's quality medical services has needlessly suffered a destructive blow.

(Footnote continued from preceding page)

guaranteed by federal law. *See* 42 U.S.C. § 1396a(a)(23). While acknowledging that corporate providers were not express beneficiaries of freedom of choice and that doctors rather than patients typically select a laboratory, the Court nevertheless adhered to the primacy of freedom of choice in concluding "that the individual's freedom of choice extends to all qualified providers of service and . . . that Congress did not intend a narrow interpretation of the provision's language". 400 F.Supp. at 1107

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Dated: October 15, 1980

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., and LAWRENCE FERGUSON, M.D.,

Plaintiffs,

vs.

ARTHUR F. QUERN, Director, Illinois Department of Public Aid,

Defendant.

No. 77 C 3943

PRELIMINARY INJUNCTION ORDER

This matter coming on to be heard on the Motion of plaintiffs, Michael Reese Physicians And Surgeons, S.C. ("Michael Reese Corporation") and Lawrence Ferguson, M.D., for a preliminary injunction enjoining defendant, Illinois Department Of Public Aid, Arthur F. Quern, Director, its employees, agents, successors, and all others acting in its behalf, from mailing or sending Medicaid payment vouchers that relate to services rendered by Michael Reese Corporation to any location other than the designated address of Michael Reese Corporation, and upon the Verified Complaint herein and the Affidavits submitted in support and in opposition of the Motion For Preliminary Injunction. The Court having heard extensive oral argument, and having reviewed memoranda of law filed by the parties hereto and being fully advised in the premises, the following findings of fact, conclusions of law and Order are entered.

FINDINGS OF FACT

1. Michael Reese Corporation is organized and certified pursuant to the provisions of Illinois law, Ill. Rev. Stat. ch. 32 § 632, *et seq.*, as a medical corporation for the purpose of treating persons at Michael Reese Medical Center Hospital, who come to the hospital without having previously chosen a staff physician. Prior to formation of Michael Reese Corporation, Medicaid patients at Michael Reese Medical Center and Hospital received medical treatment primarily from interns and residents rather than from experienced staff physicians. Since its inception in 1972, Michael Reese Corporation has provided vital medical services of the highest quality for indigents, who would not otherwise have been able to receive such care. Approximately 60% of the patients of Michael Reese Corporation are Medicaid recipients. Michael Reese Corporation is not a factor.

2. Each of the over 300 employee-physicians of Michael Reese Corporation have entered into a contract with it which requires as a condition of employment, that all fees generated by their services as employees shall be paid to the corporation. Michael Reese Corporation has provided its employee-physicians with medical equipment and resources which enhances their ability to successfully treat patients. The formation of qualified medical corporations enhances the ability of the medical profession to provide quality medical care.

3. Prior to October, 1977 the Illinois Department of Public Aid ("IDPA") made its Medicaid payment vouchers relating to services rendered by Michael Reese Corporation payable in the name of Michael Reese Corporation's employee-physicians, and mailed these payment vouchers to the corporate lock box of Michael Reese Corporation.

4. In October, 1977 IDPA commenced the practice and policy of refusing to send to Michael Reese Corporation at its lock box, or any other address, payment vouchers relating to

services rendered by Michael Reese Corporation. IDPA's policies and practices (i) of refusing to recognize Michael Reese Corporation as a medical provider, (ii) of refusing to make payable to Michael Reese Corporation Medicaid payment vouchers relating to services rendered by Michael Reese Corporation, (iii) of refusing to send to the designated address of Michael Reese Corporation Medicaid payment vouchers relating to services rendered by Michael Reese Corporation, (iv) requiring Michael Reese Corporation's employee-physicians to designate only one address for delivery of Medicaid payments regardless of whether the payments are for services rendered by the physicians individually or are for services rendered solely as employees of Michael Reese Corporation, are hereinafter referred to as "challenged policies and practices."

5. As a result of implementation of IDPA's challenged policies and practices, the monthly average of Medicaid payments received by Michael Reese Corporation (either directly or turned over to it by its employee-physicians) has decreased from $65,007.00 in 1976 and $58,056.00 in 1977 to $24,355.50 in the first four months of 1978.

6. From October, 1977 through April 1978, IDPA's challenged policies and practices has caused it to misdirect a total of 723 separate payment vouchers totaling $181,461.04 to Michael Reese Corporation and to the private practices of its employee-physicians. This has caused Michael Reese Corporation and its employee-physicians to set up expensive administrative systems for dealing with the thousands of dollars of IDPA vouchers being misdirected, and made it virtually impossible for Michael Reese Corporation and its employee-physicians to keep track of the current payment status of its Medicaid billings. This in turn has caused unnecessary and expensive duplicative billings.

7. IDPA's challenged policies and practices of sending to individual employees, vouchers payable to individual employ-

ees, for services rendered and earned by the employer corporation, subjects these employees to potential problems with Internal Revenue Service.

8. The challenged policies and practices of IDPA have contributed significantly to IDPA's lag in payment of accounts receivable to Michael Reese Corporation, and Michael Reese Corporation has incurred aged receivables from IDPA in excess of $800,000.

9. The challenged policies and practices of IDPA jeopardize the continued ability of Michael Reese Corporation's employee-physicians to participate in the medical corporation.

10. For the above reasons the challenged policies and practices of IDPA seriously threaten the ability of Michael Reese Corporation to provide the same continuing high quality of medical care to its Medicaid patients.

CONCLUSIONS OF LAW

1. This Court has jurisdiction of the subject matter herein pursuant to 28 U.S.C. 1331, pendent jurisdiction over the state claims raised herein, and jurisdiction over all parties hereto, including IDPA represented by its Director, Arthur F. Quern.

2. Plaintiffs have standing to raise all the issues which they address in their Complaint.

3. The Illinois Medical Corporation Act sanctions formation of medical corporations for the purpose of treatment of human ailments and inquires.

4. It is the intention of the Medicaid Act, 42 U.S.C. § 1396, *et seq.*, that states not arbitrarily exclude qualified corporate medical practices from participation in the Medicaid program.

5. It is the intention of the Medicaid Act that Medicaid recipients not be arbitrarily denied the freedom to choose qualified medical corporations as the sources of their physicians' services.

6. Plaintiffs have demonstrated a likelihood of success on the merits of their claims, specifically that the challenged policies and practices of IDPA are:

a. inconsistent with the provisions and requirements of the Medicaid Act, and regulations promulgated pursuant thereto, including 42 U.S.C. § 1396(a)(23), 42 U.S.C. § 1396(a)(32), 42 U.S.C. § 1396(c), 42 U.S.C. § 1396(d)(5), 45 C.F.R. § 249.20, 45 C.F.R. § 249.31, 45 C.F.R. § 250.71,

b. inconsistent with the provision and requirements of Illinois law including Ill. Rev. Stat. ch. 32, § 632, *et seq.* and Ill. Rev. Stat. ch. 23 § 23.6, and

c. violative of the Due Process and Equal Protection Clauses of the United States Constitution.

7. Plaintiffs have no adequate remedy at law and will be irreparably injured if defendant is not enjoined from its practice of refusing to direct Medicaid payment vouchers relating to services rendered by Michael Reese Corporation to Michael Reese Corporation. Defendant will suffer little or no injury from being so enjoined.

8. The public interest is served by ensuring the continued ability of plaintiffs to provide quality medical care to the indigent community pending final determination of this lawsuit.

NOW, THEREFORE, IT IS HEREBY ORDERD that defendant, Illinois Department Of Public Aid, Arthur Quern, Director, its employees, agents, successors, and all others acting in its behalf are enjoined from mailing or sending Medicaid payment vouchers that relate to services rendered by Michael Reese Corporation to any location other than the designated address of Michael Reese Corporation.

ENTER: _____

J. S. PERRY
Judge

DATED: JUNE 30, 1978

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., and Lawrence Ferguson, M.D., Plaintiffs-Appellees,

v.

Arthur F. QUERN, Director of the Illinois Department of Public Aid, Defendant-Appellant.

No. 78-2040.

United States Court of Appeals,
Seventh Circuit.

Argued April 3, 1979.

Decided Sept. 24, 1979.

Before PELL and WOOD, Circuit Judges, and HOFFMAN*, Senior District Judge.

WALTER E. HOFFMAN, Senior District Judge.

Michael Reese Physicians and Surgeons, S.C., a medical corporation organized and certified pursuant to Illinois law, and Lawrence Ferguson, M.D., a physician employed by the corporation, sought and obtained a preliminary injunction order against Arthur F. Quern, the director of the Illinois Department of Public Aid (IDPA), enjoining certain practices of the department relating to payments for physicians services rendered under the Medicaid Act, 42 U.S.C. §§ 1396, *et seq.* Specifically, the corporation objected to a change in IDPA regulations which required each physician provider under the Medicaid program to designate one, and only one, street address (i.e. not a corporate lock box) to which all payments vouchers for services to welfare recipients would be mailed. The institution of the new policy meant that payments for services rendered by physicians at the Michael Reese clinic were no longer mailed to the clinic but were instead forwarded to the individual physician-employees, unless a physician listed

* Senior District Judge Walter E. Hoffman of the Eastern District of Virginia is sitting by designation.

the clinic as his designated address. The corporation alleged that the new policy constituted a violation of law and due process and has caused irreparable injury to the clinic. The court below agreed and entered the preliminary injunction. Quern appeals from that order.

Prior to 1972, it was possible for state departments of public aid to reimburse medical providers at any address designated by the provider on the bill for services rendered. Quite frequently, physicians had their payment vouchers sent directly to factoring companies which would pay the provider at a discounted amount of the face value of the bills in exchange for an assignment of the physician's interest in the bills. In this manner, the provider obtained immediate payment for services rendered, albeit at a discounted rate. However, this system of payment was believed to be responsible for inflated and sometimes fraudulent charges for services rendered. Congress wished to eliminate factors, thereby making each provider responsible for billing for services rendered and personally liable for payments received for those services. To that end Congress enacted 42 U.S.C. § 1396a(a), which was subsequently amended to read as follows:

> § 1396a(a). A State plan for medical assistance must—
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> * * *
>
> (32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—
>
> > (A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer or (ii) (where the

> care or service was provided in a hospital, clinic, or other facility) to the facility in which care of service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and[1]

In October, 1977, IDPA commenced the practice and policy of refusing to mail Medicaid payment vouchers to corporate lock boxes, and of requiring physicians to designate one address to which all vouchers would be sent. The rationale for the policy would be sent. The rationale for the policy was to maintain stricter supervision over each recipient of Medicaid payments. In the past, corporate lock boxes had been rented by or placed under control of factors. By requiring a street address IDPA was better able to ascertain that payment vouchers were indeed mailed to a practicing physician. Secondly, by requiring each provider to designate one address to which all of his payments were to be sent, each physician could be held personally responsible for determining that he received payment only for services which he had actually rendered.

Michael Reese Corporation was organized in December, 1972, for the express purpose of treating patients who come to Michael Reese Hospital without having previously chosen a physician. Such patients are for the most part indigents and emergency care patients. Prior to the formation of Michael Reese Corporation, Medicaid patients at the hospital received treatment primarily from interns and resident physicians, rather than from experienced staff physicians. It is not disputed that since its inception the corporation has provided medical services of the highest quality for indigents. Over three hundred physicians devote a portion of their time, which could be spent

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[1] Upon passage of § 1396a(a)(32) in 1974, factors resorted to the use of powers of attorney to evade the requirements of the provision. Amendments enacted in 1977 added the language which pertains to such powers of attorney, along with a subsection (B), which is not quoted.

in private practice, to service at the clinic. As a condition of their employment at Michael Reese, the employee-physicians are required to remit to the corporation all fees generated by their services as employees.

Prior to October, 1977, IDPA issued Medicaid payment vouchers relating to services rendered by Michael Reese Corporation in the name of the employee-physicians who rendered the service, and mailed these payment vouchers to the designated address of the corporation. Vouchers relating to Medicaid services performed by the physicians in their private practices were mailed to the physician's private office. Since the institution of the new policy all Medicaid payments for private practice and clinical practice have been forwarded to one address. Michael Reese Corporation and certain of its employee-physicians have alleged that this has caused considerable confusion as to which vouchers resulted from the separate practices. The physicians have also asserted that this is likely to cause problems with their income tax returns.

Over sixty percent of Michael Reese Corporation's patients are Medicaid recipients. The court below found that in 1976, the corporation received over $65,000 in average monthly payments from IDPA, and over $58,000 per month in 1977. During the first four months of 1978, IDPA payments to Michael Reese Corporation dropped to an average of $24,355.50 a month. It was alleged that this drop in income was directly attributable to the new policy, which had allegedly resulted in the misdirection of payment vouchers and required the installation of expensive administrative systems to monitor the misdirected vouchers.

It is elementary that the starting point in every case involving the construction of a statute is the language itself. *Southeastern Community College* v. *Davis*, ____ U.S. ____, ____, 99 S.Ct. 2361, 60 L.Ed.2d 980 (1979). The language of § 1396a(a)(32) is at the core of this action. Michael Reese

Corporation contends that it should be recognized as a physician provider, entitled to receive payment in its corporate name for services rendered by employee-physicians at its facility. Alternatively, the corporation argues that subsection (A) of the provision explicitly or implicitly grants physicians the discretion to designate the clinic as the recipient of his Medicaid payment vouchers, since he is required as a condition of employment at Michael Reese to turn over his fees to the corporation. IDPA disagrees. As the agency charged with the administration of the Medicaid program in Illinois, IDPA contends that it is required by § 1396a(a)(32) to make payments directly to the physician who provides the service. Subsection (A) acts to relieve IDPA from the mandate of the provision when dealing with medical corporations such as Michael Reese; however, according to the department's reading of the provision, it remains within the discretion of IDPA to remit payment directly to the physician provider. We agree.

We note at the outset that § 1396a(a)(32) is not unambiguous. The pertinent legislative history does little to relieve that ambiguity. Congress was well aware of the role which clinical facilities such as Michael Reese play in furnishing medical attention to Medicaid recipients. Congress was also aware of the role which less reputable "Medical mills" had come to play in contributing to the escalating fraud in the Medicaid program. *See,* H.R.Rep.No. 393(II), 95th Cong., 1st Sess. 44—50, *reprinted in* [1977] U.S.Code Cong. & Admin.News, pp. 3046—3052.

In passing the Medicare and Medicaid Antifraud and Abuse Amendments, Congress required state programs to adopt certain procedures to curb abuses. Congress did not prevent state welfare departments from instituting other reforms which would fall within their discretion in administering the Medicaid programs. Medicaid is an experiment in cooperative federalism, *see, New York State Department of Social Services* v. *Dublino,* 413 U.S. 405, 413, 93 S.Ct. 2507, 37 L.Ed.

2d 688 (1973), which literally abounds with options, *Doe* v. *Beal,* 523 F.2d 611, 616 (3rd Cir. 1975), *rev'd* 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977). Medicaid is designed to be flexible enough to meet the varying needs of each state which elects to participate in the program. By approving the Illinois Medicaid plan, and by declining thus far to take any action against the modification in the plan, the Department of Health, Education and Welfare has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements. *Quern* v. *Mandley,* 436 U.S. 725, 98 S.Ct. 2068, 2076, 56 L.Ed.2d 658 (1978). The interpretation of the agency charged with administration of the statute is entitled to substantial deference. *New York State Department of Social Services* v. *Dublino, supra,* 413 U.S. at 421, 93 S.Ct. 2507.

The court below also found that the policies and practices of the IDPA in question were violative of the Due Process and Equal Protection Clauses of the United States Constitution. We can discern no such violation. In the area of economics and social welfare, a state does not violate the Constitution merely because the classifications made by its laws are imperfect; it is necessary only that the classification have some reasonable basis. *Dandridge, Chairman, Maryland Board of Public Welfare* v. *Williams,* 397 U.S. 471, 486, 90 S.Ct. 1153, 25 L.Ed.2d 491 (1970). This court cannot say that the IDPA policies at issue have no reasonable basis in combatting the very real problem of Medicaid fraud and abuse.

Finally, we find no violation of the provisions or requirements of Illinois law. Illinois allows physicians to incorporate their practices, and Congress clearly anticipated that Medicaid services would frequently be provided by clinics operating as corporations. It does not follow that a state may not elect to pay physicians as individuals for the services they perform, rather than making payments to the legal entity under which they practice. Indeed, prior to the institution of the present policy, IDPA had always made payment in the name of the

physician, rather than to the Michael Reese Corporation. Section 1396a(a)(32) recognizes that in the normal circumstance payments should be made to the individual performing the service. That section goes on to create an exception for employee-physicians. For the reasons stated above, we hold that the exception acts to relieve the state Medicaid program from the requirement of paying the individual physician; it does not require the program to make payment to the employer upon the request of the physician.

In closing, we note that this is basically a matter between the Michael Reese Corporation and its physician-employees. If the corporation can require its physicians to turn over all the fees they generate as employees to the clinic, it can also require them to list the clinic as their designated address with IDPA[2] If the corporation is not receiving payments from its employees, it is for one of two reasons: either the physicians are unable to administratively keep up with the services for which they are being paid, or they are willfully failing to turn over the payment vouchers. Both explanations reflect the reasons why IDPA instituted the new policy. Physicians were either unaware of the services being billed in their names, leading to inflated and fraudulent charges on the part of third parties, or else the physician-employees are failing to remit payment vouchers to Michael Reese for services performed at the clinic, then the corporation itself is in a much better position to police its employees than is the Illinois Department of Public Aid.

The decision of the court below is reversed with directions to dissolve the injunction.

REVERSED.

PELL, Circuit Judge, dissenting.

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[2] The record indicates the IDPA had offered to create separate vouchers, even though it would not agree to send them to different addresses.

The majority opinion unfortunately perpetuates a rigidly anserine bureaucratic ruling to the detriment of an orderly handling of the needs of public health. I therefore respectfully dissent.

No one can seriously quarrel with a governmental desire to eliminate all unnecessary expenditures of public funds on social programs such as that here involved. The anti-factoring legislation was designed for that very purpose. Congress, on the other hand, recognized that there are legitimate clinics such as Michael Reese which are rendering services through salaried employees and expressly permitted the payment to be made to the corporate employer. Congress has thereby declared the policy that payments made directly to the employer are not violative of the anti-factoring precepts but are indeed payments to the party entitled thereto not to someone who has no legal claim.

The state here in an attempt to justify its wooden and unbending insistence on making payments to individuals known to the state not to be entitled thereto ultimately basically resorts to a Pandora's box argument that Medicaid mills "and even factors will attempt to utilize this to their full advantage." The case before us, however, involves a bona fide employer, the very kind contemplated in the Congressional exception to the requirement of direct payment to the individual; no one argues otherwise. The state has to do no more to fasten tight the lid of the famed troublous box than to require adequate documentary proof of the bona fide employer status. The majority opinion suggests that Michael Reese can require the physicians to list the clinic as their address. Elsewhere in the majority opinion there is reference to the state regulation requiring the physician "to designate one, and only one, street address." Inasmuch as many of the physicians are also in private practice, I do not understand that the physicians can furnish more than one street address dependent upon whether they are in the private sector or the employment capacity as to a particular billing.

The state on this appeal emphasizes that the word "may" is permissive and argues therefore that the payment is discretionary and then leaps to the farther point that the exercise of that discretion is lodged with the state administrator. The majority opinion while not apparently relying expressly on the always arguable equation of "may" with permissiveness, nevertheless also concludes that the discretion is solely that of the state. Insofar as the significance of the word "may" is concerned, one need only riffle through the appropriate volume of Words and Phrases to be aware of the substantial attempts of judicial opinions to try to determine whether "may" means "shall" or merely something in the nature of "optional." The cases, in the matter of the statutes, generally end up by referring to the intent of the legislature. Here, the guidance from legislative history does not seem to tell us much except Congress was concerned about excessive claims resulting from factoring. That concern was expressly delimited so as to exclude employers.

In any event, I agree with the majority that on the matter of legislative intent resort should be first had to the words of the enactment themselves. Here the basic statute, pre-exceptions, requires that the plan "must provide" that no payment shall be made to anyone other than the provider of the service. The exceptions clauses do not state that nevertheless the plan may provide for the payment to be made to the employer of the provider of service; instead the exceptions deal with the actual payment notwithstanding the mandatory language required for the plan. This could not very well have been worded in terms that in the event of employment the payment "shall" be made to the employer. Conceivably some employers might prefer that the physician directly do the billing with the amounts received to be credited against his salary obligation. In other words, the "may" in the statute just as logically, because it deals with the payment not the provisions of the plan, can be construed to refer to a discretion on the part of the employer to determine whether it or its employees directly shall bill for and receive payments.

The state by its unbending resistance to the orderly procedure whereby one source, instead of multiple providers, submits billings has demonstrably been detrimental to a valued public health service in this area. This is understandable when it is recalled that the physicians also frequently render services in their private practice for which payments are made. I do not deem it necessary as did Judge Perry to reach the constitutional issue, although I regard the situation as it has developed as involving serious constitutional questions. In my opinion, the state has no choice in the case of a bona fide employer except to pay that employer, if the employer so desires, for the services rendered by its employees. Even, however, if the discretion were considered to rest only with the state rather than the employer, on the facts of the present case, there seems to me to be such a patent abuse of discretion that the injunction granted below should be affirmed.

IN THE

United States Court of Appeals

FOR THE SEVENTH CIRCUIT

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., and LAWRENCE FERGUSON, M.D.,

Plaintiffs-Appellees,

v.

ARTHUR F. QUERN, Director, Illinois Department of Public Aid,

Defendant-Appellant.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 77-C-3943—**Joseph S. Perry,** *Judge.*

REHEARD IN BANC JUNE 16, 1980—DECIDED JULY 18, 1980

Before FAIRCHILD, *Chief Judge,* SWYGERT, CUMMINGS, PELL, SPRECHER, BAUER, WOOD, and CUDAHY, *Circuit Judges.*

PER CURIAM. A panel of this court initially issued an opinion, reported at 606 F.2d 732, which ordered that the preliminary injunction granted plaintiffs-appellees, Michael Reese Physicians and Surgeons, S.C., and Lawrence Ferguson, M.D., be dissolved. Based upon the plaintiffs-appellees' petition for rehearing with a suggestion that the case be reheard *in banc,* a majority of the judges in regular active service on this court voted to rehear the case *in banc.* Following reargument a

majority of the judges in regular active service on the court decided to adopt the original panel decision dissolving the preliminary injunction.

Judge Pell, for the reasons stated in his dissent from the panel opinion, 606 F.2d at 736, dissents from this decision. Judge Cummings joins in Judge Pell's dissent and adds additional reasons for dissenting.

CUMMINGS, *Circuit Judge,* with whom PELL, *Circuit Judge,* joins, dissenting. I join in Judge Pell's original dissent, but I write separately to highlight some additional reasons, first advanced at the *en banc* oral argument, that support affirmance.

When Congress enacted the 1977 Medicare-Medicaid Antifraud and Abuse Amendments to the Social Security Act, the amended Section 1902a(a)(32) of the Act read in pertinent part as follows:

"(a) A state plan for medical assistance *must*—

* * * * *

"(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the *person* or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

"(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service * * *" (Italics supplied; 42 U.S.C. § 1396a(a)(32).)

Prior to the amendment, said paragraph (a)(32) stated in pertinent part:

> "(a) A State plan for medical assistance must—
>
> * * * * *
>
> "(32) provide that no payment under the paln for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner * * * ."

The central purpose of the amendment was to stop the common practice of factoring Medicare and Medicaid bills. That practice depended on the physician's use of a power of attorney that "allows the factoring company to receive the Medicare or Medicaid payment in the name of the physician, thus allowing the continuation of a program abuse which factoring activities were shown to produce in the past." House Report No. 95-393, Part II (95th Cong., 1st Sess. 1977) at 49, reproduced in 3 U.S. Code Congressional and Administrative News (95th Cong., 1st Sess. 1977) at 3051. No such practice is involved here, and Congress expressly recognized this fact. Thus although the 1977 Amendments prohibit the states from making payments to "anyone other than" certain named entities under an assignment or power of attorney, it specifically included among the entities entitled to receive payments "the person * * * providing such care or service." Under 1 U.S.C. § 1, a "person" includes a corporation. It follows then that Congress explicitly permitted a corporation such as Michael Reese Physicians & Surgeons, S.C. (MRPS) to receive the payments at issue here.

It would make no sense for Congress to place a corporation such as MRPS within the class of allowable recipients only to have it removed by a state. Although the Illinois Department of Public Aid may argue that the statute prohibits only an expansion of the class of payees and that the Department has

merely reduced the size of the class in the interest of furthering the Congressional intent, I do not believe a state should be able to substitute for the judgment of Congress its own notions on how to eliminate factoring. Since Congress clearly believed it was unnecessary to prohibit corporations such as MRPS from receiving payments, Illinois' attempt to do so is contrary to the intent of the statute.

Although under other circumstances I might hesitate to draw from language permitting a state to make payments to MRPS the conclusion that Illinois must allow MRPS to receive payments, such an approach to the statutory intent is justified by two specific items in the legislative history. First, on March 3 and 7, 1977, Samuel Skinner, then United States Attorney for the Northern District of Illinois, testified regarding the anti-factoring provisions during the joint hearings held in the House of Representatives on the proposed amendments to the Act. Joint Hearings of the Subcommittee on Health, Committee on Ways & Means and Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives (95th Cong., 1st Sess., March 3 and 7, 1977) at p. 28. He suggested to the Subcommittee that the plan payments be made "directly to the individual who certifies that he has rendered the medical services, rather than making the payment to the provider who then will have the responsibility of turning it back to the individual practitioners." *Id.* at 31. See also *id.* at 36. In other words, Mr. Skinner recommended restrictions very similar to those that are currently reflected in the Illinois Department of Public Aid regulations. The legislative record indicates, however, that his recommendation was rejected by the Subcommittee and the Committee staff, even though the Department of Health, Education and Welfare supported the provision. Staff Report on H.R. 3, Medicare-Medicaid Anti-Fraud and Abuse Amendments, Subcommittee on Health of Committee on Ways & Means, U. S. House of Representatives (95th Cong., 1st Sess., March 28, 1977) at p. 2.

Second, the House Committee Report expressly stated that Section 1936a(a) as amended in 1977 would permit the use of billing agents such as MRPS. It stated:

> "The bill would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. The bill also provides for similar prohibitions with respect to billings for care provided by institutions under medicare and medicaid. However, it would not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the agency does so pursuant to an agreement under which the compensation paid the agency for his services or for the billings or collections of payments is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of billing agents by doctors and others, when the agents are paid on a basis related to the cost of doing business and not dollar amounts billed or collected, would not be precluded. The bill would not impose any limitations on the use of billing or collection agencies for payments owed by anyone other than the medicare or medicaid programs. Nor is it the committee's intention that this provision preclude the legitimate transfer of accounts receivable from these programs by an individual or an institution upon the 'sale' of the individual's practice (for example upon retirement) or as part of the sale of all the assets of an institution." (3 U.S. Code Congressional and Administrative News (95th Cong., 1st Sess., 1977) 3051-3052.)

The same language appears in Senate Finance Committee Report No. 95-453 (95th Cong., 1st Sess. 1977) at p. 7. This language reflects Congress' command that state plans must prevent a physician from employing a power of attorney but

preserve his ability to use an agent. Illinois has taken action here directly contrary to this Congressional purpose.[1]

As explained at the *en banc* oral argument, unless the payments are made to plaintiff corporation or at the very least to physicians at the corporation's address, the physicians will receive payments at their own offices and may not remit any amounts to the corporate plaintiff. The result will be that the corporate plaintiff will be forced to close shop. In my view, the 1977 Congressional Amendments permitted payments to the plaintiff corporation in order to prevent such a result. The regulations under attack here cannot survive when the statute is so interpreted.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

[1] This construction does not make the exception clause in Section 1936a(a)(32) meaningless because, as plaintiffs' counsel stated, it would still perform a valid function in states that do not have a medical corporation law system such as that in Illinois.

Supreme Court, U. S.
FILED
DEC 9 1980
MICHAEL RODAK, JR., CLERK

No. 80-635

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., AND LAWRENCE FERGUSON, M.D.,

Petitioners,

v.

JEFFREY C. MILLER, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

STATE RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether a participating state in administering its Medicaid program is required to recognize and compensate as a provider of qualified services a medical corporation consisting of physicians who provide quality treatment to indigent patients.

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No. 80-635

IN THE

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OCTOBER TERM, 1980

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., AND LAWRENCE FERGUSON, M.D.,

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JEFFREY C. MILLER, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

STATE RESPONDENT'S BRIEF IN OPPOSITION

The respondent, Jeffrey C. Miller,[1] Director of the Illinois Department of Public Aid respectfully requests that this Court deny the petition for a writ of certiorari seeking review of the court of appeal's opinion in this case.

[1] Arthur F. Quern resigned as the Director of the Illinois Department of Public Aid, effective September 1, 1979. Jeffrey C. Miller has been appointed as the Director of the Illinois Department of Public Aid. Supreme Court Rule 40.3 provides that under such circumstances Jeffrey C. Miller should be automatically substituted as a party.

OPINIONS BELOW

The *en banc* opinion of the court of appeals (Pet. App. 17a) is reported at 625 F.2d 764. The original panel opinion of the court of appeals (Pet. App. 7a) is reported at 606 F.2d 732. The memorandum order of the district court (Pet. App. 1a) is unreported.

JURISDICTION

The judgment of the court of appeals upon rehearing *en banc* was entered on July 18, 1980 and the petition was filed within 90 days thereafter. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

The Illinois Department of Public Aid (IDPA) is the state agency responsible for administering Illinois' participation in Title XIX of the Social Security Act, 42 U. S. C. § 1396a *et seq.*, commonly referred to as the Medicaid program. Prior to 1972, it was common practice throughout the country for state departments of public aid to reimburse medical providers participating in the Medicaid program at any address designated by the provider on the bill for services rendered. Quite frequently, such physicians had their payment vouchers sent directly to factoring companies which would pay the provider at a discounted amount of the face value of the bills in exchange for an assignment of the physician's interest in the bills. This enabled the provider to maintain a consistent cash flow and the factoring company to reap the profits over and above the percentage of the bill it paid to the provider. This system of payment, however, was found to be fraught with fraud and abuse. *See* H.R. Rep. No. 92-231, 92d Cong., 2d Sess. (1971), *reprinted in* [1972] U.S. CODE CONG. & ADMIN NEWS

4989, 5090. Prior to the submittal of bills, factors were able to alter and inflate the amount and types of services rendered without the knowledge of the providers. Providers had no opportunity to detect such fraud or abuse because payment was made directly to the factoring companies. Moreover, providers refused to take personal responsibility for ensuring that the bills submitted reflected charges for services actually rendered.

Such problems of fraud and abuse by those associated with the Medicaid program in Illinois are well documented. As the court noted in *Professional Factoring Service Assoc.* v. *Mathews,* 422 F. Supp. 250, 256 (S.D.N.Y. 1976):

> [I]n various memorandum and investigative reports [in files of the United States Department of Health, Education and Welfare] there were references to inflated and fabricated billings by factors, especially in Illinois, where reassignment of claims via powers of attorney was occurring on a large scale.

See SUBCOMM. ON LONG TERM CARE, SP. COMM. ON AGING, 94th CONG. 2D Sess., FRAUD AND ABUSE AMONG PRACTITIONERS IN THE MEDICAID PROGRAM, 1-3, 18-19, 45-48 (Comm. Print 1976). Motivated by such evidence of fraud and abuse, Congress enacted 42 U.S.C. § 1396a(a) (32) which requires in part that a state Medicaid plan must provide that no payments for services provided by a physician, dentist or other individual practitioner shall be made to anyone other than such individual.

In October, 1977, IDPA commenced the practice and policy of requiring each physician provider under the Medicaid program to designate one street address to which all payments for services to welfare recipients would be mailed. The use of postal lock boxes was not permitted. The rationale for this policy was to maintain stricter supervision over each recipient of Medicaid payments. In the past, corporate lock boxes had been rented by or placed under the control of factors. By requiring a

street address IDPA was better able to ascertain that payment vouchers were indeed mailed to the practicing physician. Moreover, by requiring the provider to designate one address to which all of his payments were to be sent, each physician could be held personally responsible for determining that he received payment only for services which he had actually rendered.

Petitioner, Michael Reese Physicians and Surgeons, S.C. was organized in December, 1972 for the express purpose of treating patients who come to Michael Reese Hospital without having previously chosen a physician. Prior to petitioner's inception, Medicaid patients at the hospital received treatment primarily from interns and resident physicians, rather than from experienced staff physicians. Over three hundred physicians devote a portion of their time to service at the clinic. As a condition of their employment, these employee-physicians are required to remit to petitioner all fees generated by their services to Medicaid recipients.

On October 6, 1977, petitioner filed this action challenging both IDPA's one address mailing policy and its practice of refusing to recognize medical corporations as physician providers under the Medicaid Act. The district court entered a preliminary injunction order which enjoined IDPA from sending Medicaid payments for services rendered by petitioner's employee-physicians to any address other than petitioner's designated corporate lock box. *See* Pet. App. 6a.

On appeal, the court of appeals reversed. (Pet. App. 7a-13a) The court first recognized Congress' concern with the effect that less reputable "Medicaid mills" had in contributing to escalating fraud in the Medicaid program. Noting the wide flexibility which Congress had vested in the states in the design of their individual Medicaid programs, the court observed that "Congress did not prevent state welfare departments from instituting other reforms which would fall within their discretion in administering the Medicaid programs." (Pet. App. 11a-12a) Moreover, in light of the Department of Health,

Education and Welfare's approval of Illinois' Medicaid plan, the court held that the agency's interpretation was entitled to substantial deference. (Pet. App. 12a) The court also rejected petitioner's claim that IDPA's practices violated the Due Process and Equal Protection Clauses of the United States Constitution, holding that IDPA's practices were reasonably related to combating the problems of Medicaid fraud and abuse. (Pet. App. 12a) In addition, the court recognized that the instant case presented a dispute between petitioner and its physician-employees rather than with IDPA. (Pet. App. 13a) Following rehearing *en banc,* a majority of the court of appeals adopted the original panel decision. (Pet. App. 17a-18a)

ARGUMENT

Petitioner extolls the "unique benefits" which medical corporations are able to offer the Medicaid patient and argues that unless this Court considers the statutory and constitutional questions presented in this petition for a writ of certiorari, it will be "forced to close shop." (Pet. 6-8) This "needlessly harsh result of banishing medical corporations from the Medicaid program", petitioner claims, provides ample reason for this Court to grant the writ of certiorari.

This argument fails to present any convincing reason why a writ of certiorari should be granted. This Court has set forth the various considerations which would enter into its determination to grant certiorari in a given case in Supreme Court Rule 17.1. There is absolutely no indication in that rule that the petitioner's continued economic survival is a factor which would in any way motivate this Court to exercise its jurisdiction.

Moreover, petitioner's argument fails to take into account the fact that any threat to its continued economic viability is not the direct result of IDPA's practices. As the court of appeals stated:

> [W]e note that this is basically a matter between the Michael Reese Corporation and its physician-employees. If the corporation can require its physicians to turn over all the fees they generate as employees to the clinic, it can also require them to list the clinic as their designated address with IDPA. If the corporation is not receiving payments from its employees, it is for one of two reasons: either the physicians are unable to administratively keep up with the services for which they are being paid, or they are willfully failing to turn over the payment vouchers. Both explanations reflect the reasons why IDPA instituted the new policy. Physicians were either unaware of the services being billed in their names, leading to inflated and fraudulent charges on the part of third parties, or else the physician-employees are failing to remit payment vouchers

> to Michael Reese for services performed at the clinic, then the corporation itself is in a much better position to police its employees than is the Illinois Department of Public Aid. (Pet. App. 13a) (footnote omitted)

As between these two postulated explanations, petitioner has admitted that the latter is, in fact, the case. As one of the dissenting judges noted below:

> As explained at the *en banc* oral argument, unless the payments are made to plaintiff corporation or at the very least to physicians at the corporation's address, *the physicians will receive payments at their own offices and may not remit any amounts to the corporate plaintiff.* The result will be that the corporate plaintiff will be forced to close shop. (Pet. App. 22a) (emphasis added)

As both the majority and the dissent realized, this case presents a dispute between petitioner and its physician-employees as to whether such employees will remit payments to petitioner for services performed in petitioner's clinic. IDPA's practices can only be characterized as causing indirect injury to petitioner as a result of the exercise of lawful power. While petitioner may have legal rights against its employees for their failure to remit their payments, the mere fact that they do not turn over such payments does not present an important issue of federal law that should be decided by this Court. *See O'Bannon* v. *Town Court Nursing Center,* ____ U.S. ____, 100 S. Ct. 2467, 2476-77 (1980).

II.

THE DECISION OF THE COURT OF APPEALS IS PLAINLY CORRECT.

The state respondent believes that a detailed argument on the merits of the federal statutory and constitutional issues is unnecessary, and that the opinion of the court of appeals as to the questions presented by petitioner is well reasoned and

correct. Since petitioner has urged, however, that Congress mandated that the states include medical corporations as physician-providers under the Medicaid program, a brief discussion of this argument is appropriate.

The majority decision of the court of appeals properly recognized that Medicaid is an experiment in cooperative federalism, allowing the states broad options in shaping the details of their program. (Pet. App. 11a) *See Harris* v. *McRae*, ____ U.S. ____, 100 S. Ct. 2671, 2683-85 (1980); *New York Dept. of Social Services* v. *Dublino*, 413 U.S. 405, 413 (1973); *King* v. *Smith*, 392 U.S. 309, 316 (1968). The court also recognized that Illinois' Medicaid plan, including the provision which limits participation and accountability to individual physicians, has been approved by the Department of Health, Education and Welfare as in compliance with the requirements of Title XIX of the Social Security Act and HEW's regulations. (Pet. App. 12a)

It is a well established principle of statutory construction that "[t]he interpretation of a statute by an agency charged with its enforcement is a substantial factor to be considered in construing the statute." *Youakim* v. *Miller*, 425 U.S. 231, 235-36 (1976). *Accord Johnson* v. *Robinson*, 415 U.S. 361, 367-68 (1974); *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965). As long as the agency's interpretation is reasonable and there is no "compelling indications that it is wrong", the agency's construction should be given great deference. *Beal* v. *Doe*, 432 U.S. 438, 447 (1977); *New York State Dept. of Social Services* v. *Dublino, supra*, 413 U.S. at 405; *Red Lion Broadcasting Co.* v. *F.C.C.*, 395 U.S. 367, 381 (1969).

Congress, at the time it enacted the amendment to 42 U.S.C. 1396a(a)(32) banning the reassignment of claims and restating the state's option to mail payments either to individual physicians or their employers, recognized the problems which

the IDPA policies are designed to correct. The legislative history concerning the practice of assigning physicians' claims to other entities states that:

> Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. H.R. REP. NO. 92-231, 92nd Cong., 2d Sess. (1971), *reprinted in* [1972] U.S. CODE CONG. & ADMIN. NEWS 4989, 5090.

It is just these problems that the one address rule and requirement that each individual physician bill and be responsible for services rendered to Medicaid recipients are designed to meet. The problems associated with allowing Illinois Medicaid providers to have their payments made to third parties are well documented. *See United States* v. *Ziperstein*, 601 F. 2d 281, 284-285 (7th Cir. 1979). The Department's requirement that each physician designate one office (or home) address at which he will receive Medicaid payments is the state's attempt to insure that physicians will be aware of just what services are being billed in their name. It is not unreasonable to assume that the abuses detailed in *Ziperstein* might not have occurred had such a rule been in effect at that time.

IDPA, as the agency charged with the administration of the Medicaid program in Illinois, has the necessary discretion under the Medicaid Act to impose its one address rule. Petitioner has failed to present any compelling reasons to show that there is a violation of either the purpose or intent of the Medicaid Act by IDPA's one address rule for physician payments.

Petitioner has also claimed that the court of appeals' opinion failed to consider whether IDPA violated the Medicaid Act freedom of choice provisions, 42 U.S.C. 1396a(a)(23), by refusing to recognize the corporation as a physician provider. This section provides that a state plan must provide that recipients may obtain medical assistance from any qualified individual or institution. HEW regulations interpreting 1396a(a)(23) pro- vide:

> **Free choice of providers.**
>
> (a) This section implements section 1902(a)(23) of the Act, which provides that recipients may obtain services from any qualified medicaid provider.
>
> (b) A State plan (except in Puerto Rico, the Virgin Islands, and Guam) must provide that any recipient may obtain medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. . .
>
> (d) Paragraph (b) of this section does not prohibit the agency from—
>
> (1) Establishing the fees it will pay providers for medicaid services; or
>
> (2) Setting reasonable standards relating to the qualifications of providers. 42 C.F.R. § 431.51 (emphasis added)

IDPA has always restricted participation to *individual* physicians who provide the hands-on services to eligible recipients. (Pet.App.12a) Applicable provisions of the IDPA *Handbook for Physicians* provide that;

> A—201 *Physician Participation*
>
> A Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois license to practice medicine in all its branches, is eligible for approval to participate in the Medical Assistance Program. . .

A—202.1 *Charges*

A physician may charge only for services he personally provides, or which are provided under his direct supervision in his office by his staff, e.g. laboratory services done by a technician in his employ.

A physician may not charge, however, for services provided by another physician even though one may be in the employ of another.

The federal Medicaid regulations define "physicians services" as services provided "[b]y or under the direct supervision of an individual licensed under state law to practice medicine or osteopathy." 42 C.F.R. 440.50(b).

The exclusion by IDPA of Michael Reese Corporation itself as a qualified provider of physicians services entitled to payment in its own name is within the state's discretion and clearly contemplated by both applicable federal and state regulations.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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Respondent.

AMICUS CURIAE BRIEF OF ILLINOIS STATE MEDICAL SOCIETY IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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The Illinois State Medical Society ("ISMS"), as amicus curiae, respectfully joins in the Petition of Michael Reese Physicians and Surgeons, S.C., and Lawrence Ferguson, M.D. in requesting that a writ of certiorari issue to review the judgment entered July 18, 1980 of the United States of Appeals.

QUESTION PRESENTED

Whether a participating state in administering its Medicaid program is required to recognize and compensate as a provider of qualified services a medical corporation consisting of physicians who provide quality treatment to indigent patients.

STATEMENT OF INTEREST

ISMS is the largest statewide organization of physicians in Illinois, representing in excess of 14,000 physicians, or more than 80 percent of the licensed physicians in the State. Many of these physicians practice as sole practitioners, while substantial numbers are organized in group practices such as corporations organized pursuant to the Illinois Medical Corporation Act. ISMS sponsors a wide variety of programs directed to improving the quality and cost effectiveness of public health. ISMS publishes monthly the Illinois Medical Journal which contains analysis of current public health problems as well as authoritative scientific articles. ISMS also offers its members assistance in dealing with the Illinois Department of Public Aid ("IDPA") with regard to Medicaid reimbursement, and is actively involved in addressing problems raised under the administration of the state Medicaid program.

As a result of its comprehensive involvement in the administration of public health in Illinois, ISMS has become vitally concerned about the exclusion by IDPA of medical corporations from participation in the Illinois Medicaid program. In November, 1976 the House of Delegates of ISMS, on behalf of its membership, formally repudiated IDPA's unreasonable refusal to recognize medical corporations as a participant in the Medicaid program. The House of Delegates of ISMS is a policy-making body of the organization chosen to represent 92 county medical societies of Illinois.

REASONS FOR GRANTING THE WRIT

ISMS adopts in full the Reasons For Granting The Writ set forth in the Petition For A Writ Of Certiorari filed in this case. IDPA's insistence upon excluding medical corporations from the state Medicaid program is based upon a total misconception of the manner in which public health needs are met in the State of Illinois.

The Illinois medical corporation today offers benefits in quality and cost effective medical treatment that cannot always be provided by sole practitioners. The medical corporation is a modern means for providing high quality medical expertise across a variety of highly specialized areas of medical practice. By excluding medical corporations from the Medicaid program, IDPA is drastically reducing the otherwise available volume of physicians able to service the indigent. For example, a 1975 survey of group medical practice identified 3,004 group practice physicians in Illinois, 1,973 of whom were involved with groups providing multispecialty expertise for their patients. For the reasons stated in the Petition, the inferior medical treatment offered the indigent as a result of IDPA's exclusion of medical corporations is at odds with the Medicaid Act. The effect of this arbitrary exclusion severely impacts on the public health care offered the needy in Illinois.

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Dated:

Respectfully submitted,

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